CON COMMISSION TESTIMONY

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I. Introduction

A. Thanks

B. MAG

1. Largest physician organization in the state, the voice of medicine

2. MAG's Mission: to enhance patient care and the health of the public by advancing the art and science of medicine

3. Clear interest in the work of the Commission

C. Goal of Testimony

1. Demonstrate the clear public policy interest in enhancing the ability of Georgia's patients to receive high quality care at physician-owned ambulatory surgery centers and diagnostic and treatment facilities

    a. Interest of patients because receive high-quality care at convenient times and locations
    b. Interest of employers and taxpayers who fund healthcare because cost of care at physician owned centers is much less than in a hospital setting.

2. Demonstrate how the current CON Act and regulations have been used as an anticompetitive tool by certain hospitals to squelch competition from physician-owned centers

3. Make specific recommendations to the Commission for revising CON Act

II. Background

A. National Health Planning and Resources Development Act

1. Belief that supply for healthcare services created demand for Services

2. Therefore, controlling the number of facilities would help control The amount of healthcare services sought and consequently the costs.

3. Theory that "practice makes perfect:" the more procedures Performed, the more expertise

4. Law was repealed in 1985

5. Sixteen states have abolished CON laws

B. FTC DOJ Report

1. CON NOT effective in controlling health care costs

2. CON erodes consumer welfare
--inhibits innovation and alternatives to costly treatments

3. Urges states to reconsider whether CON programs are effective

4. "The Agencies believe that, on balance, CON programs are not successful in containing healthcare costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market. …..Indeed, there is considerable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns." (p. 20)

C. Georgia's CON Act

1. Need a CON to develop a "new institutional health service" O.C.G.A. 31-6-40(a)

2. Ambulatory surgery is considered a "new institutional health service" except that "surgery performed in the offices of an individual private physician or single group practice of private physicians if such surgery is performed in a facility that is owned, operated, and utilized by such physicians who are also of a single specialty and the capital expenditure associated with the construction, development, or other establishment of the clinical health service does not exceed…" the then current capital expenditure.

3. What does this mean?

    a. Physician-owned single specialty ambulatory surgery Centers do not need a CON

        1. Instead, they typically apply for a letter of non-reviewability, commonly referred to as an "LNR" which states that their project qualifies for the exemption

        2. Keep in mind: THERE IS NOTHING IN THE CON ACT ABOUT LNRs; they are simply a regulatory creation

    b. CONs are likewise not required for surgery performed in physicians' offices

    c. CONs are required for

        1. Physician-owned multi-specialty ambsurg centers

        2. Centers constructed for more than the capital threshold (currently $1.5 million)

        3. And, because DCH arbitrarily classifies general surgery as a multi-specialty, ambsurg centers for general surgery

        4. CONs required for diagnostic and therapeutic equipment costing more than the capital threshold (currently $775,103)

4. Alliance consistently refers to the exemption for physician owned Centers as an "unintended loophole"

    a. Disagree

    b. When construing legislative language, courts also look at the clear meaning of words

    c. "this provision shall not apply …..if such surgery is performed in a facility that is owned, operated, and utilized by such physicians who are also of a single specialty and the capital expenditure association with the construction, development, or other establishment….does not exceed…."

III. Physician Owned AmbSurg Centers are in the Public Interest

A. Why?

1. High quality care

2. Lower cost to payors of healthcare services than care provided in the hospital setting

3. Access to state-of the art equipment in convenient locations

4. Tool to recruit specialists to rural areas, benefiting both patients in those areas and the economy.

5. Summary of public policy reasons for promoting ambsurg centers expressed in the November 18, 2003 draft component state health plan: "The increase in the number of surgeries performed in freestanding ASCs has outpaced the growth of hospital outpatient departments and physician offices. Payor incentives, patients convenience, and physician preference can be attributed to the growth in the volume of surgeries performed in freestanding outpatient settings. Payors may cover more of the cost for patients that receive services in an ambulatory surgery center. Some data suggest that patients may prefer the more convenient locations, lower insurance co-payments, decreased exposure to infectious agents, and timely appoint scheduling that are provided by ambulatory surgery centers."

B. Quality

1. Talk about quality <u>solely</u> in the context of public interest.
--CONs are not awarded to all quality facilities that apply; rather awarded based on need.

2. Alliance says that physician owned ambsurg centers are not regulated
--not accurate: ORS responsible for licensing ASCs

a. ORS conducts annul surveys to assure that ASCs meet exacting physical and operational standards designed to protect patients, staff and visitors.

b. ORS also surveys ASCs which seek Medicare reimbursement every three years for Medicare certification purposes.

c. Most private health plans require that ASCs be accredited by a nationally recognized organization, such as the Joint Commission for Accreditation of Healthcare Organizations ("JCAHO") or the Association for Accreditation of Ambulatory Healthcare ("AAAHC")

3. Department of Health and Human Services, Office of the Inspector General Report found that quality of care provided in freestanding ambsurg centers is comparable to care provided in the hospital setting.

4. Studies cited by Alliance relate to issues with quality in office-based surgery NOT with respect to ambsurg centers.

   [OIG reports criticize some states' oversight of ambsurg centers NOT quality of care at ambsurg centers.]

5. There is also considerable evidence showing that CON regulations generally tend to negatively impact the quality of care delivered because they delay the entry of entities that could provide higher quality services than existing facilities..

   a. FTC stated as early as 1988, that CON regulations "foster lower quality and reduced innovation in health care markets." (FTC Bureau of Economics, Staff Comments to Georgia State Senator Culver Kidd, March 7, 1988)

   b. Georgia State University study concluded that CON regulations have "lowered the quality of healthcare services" and that there is "little or no evidence that states with CON regulations have access to care or higher quality of care than states without CON regulation."

   c. One study examining the causal relationship between CON regulations and the quality of care determined that states with rigorous CON regulations had mortality rates 6% higher than states without rigorous CON regulations among Medicare patients.

6. Alliance of Community Hospitals regularly attempt to argue that quality of care is lower in freestanding ambsurg centers based on studies examining surgery in physicians offices NOT in ambsurg centers where licensure works to assure quality.

C. Lower Costs

1. Generally recognized that cost of providing care at a freestanding ASCs much less than providing care in a hospital.

2. OIG Report: "ASCs can significantly reduce the costs for Federal healthcare programs, while simultaneously benefiting Patients."

3. GA Medicaid currently pays twice as much for ambulatory surgery performed in hospitals as opposed to freestanding ASCs.

D. Consistent with general information that CON laws increase costs

1. FTC/DOJ Report

2. 1987 study showed that hospital expenses higher in states with CON laws.

3. GA State University study concluded that CON regulation is "ineffectual in restraining health care costs." That study also looked at 16 studies and found that only one of them found a decrease in costs in CON states and that study was methodologically flawed.

E. Respond to GHA and Alliance of Community Hospitals Argument that physician-owned ASCs are not in the public interest because these facilities "cherry pick" patients, allegedly siphoning off revenues necessary to keep ERs open.

1. Not accurate: physicians feel an obligation and DO treat indigent and Medicaid patients.

2. Hospitals forget that it is PHYSICIANS who provide the care in ER, often in the middle of the night and without pay whereas the hospitals can and do collect from the Indigent Care Trust Fund.

IV. Current Law Has Been Used Anticompetitively to Stymie Development of Physician Owned Centers

A. Reminder: The CON Act does not contain ANY mention of LNRs.

1. Rather, the CON Act creates an exception for single specialty physician owned ambsurg centers constructed for less than the capital threshold.

2. THERE SHOULD BE NO ROLE FOR COMPETITORS IN THIS PROCESS.

B. Stated Goal of Community Hospitals: To stop the "proliferation" of physician-owned ambsurg centers

C. How are They Seeking to Accomplish this Goal?

1. Filing Mandamus Actions in Court Seeking Orders directing DCH to rescind the LNRs.

2. According to a recent deposition of Monty Veazy, the Alliance files these actions in any case in which a physician owned center would compete with one of its member hospitals and they would do this even if the impacted hospital did not support the challenge!

3. Moreover, the Alliance is using these actions to conduct wide ranging discovery even though a mandamus action is supposed to be limited to the administrative record below.

4. Filing these actions every time an LNR is granted even though the legal standard is gross abuse of discretion.

5. Impact:

a. Patients deprived of ability to get high quality care from the physician of their choice in a physician owned center

b. Increased costs to healthcare system through unnecessary legal costs--by the way, the Alliance always seeks to recover their legal fees

c. Unnecessary costs to taxpayers because state has to expend resources to defend these actions, including the cost of responding to significant discovery

D. Other Anticompetitive Behaviors

1. TAC

a. Physician interests consistently outvoted by hospital interests

b. e.g. interventional radiology not added as single specialty despite testimony that cancer patients need access to this specialty and many hospitals don't have the equipment.

2. General Surgery

    a. General surgery is universally recognized as a separate specialty by organized medicine.

    b. Separate residency; specific board

    c. Even DCH qualifies general surgery as single specialty for annual hospital survey forms

    d. Court of Appeals decision stands only for the proposition that DCH had the authority classify general surgery as a single specialty, not that DCH could never change its rules and in fact DCH has changed its rules since CON Act was amended.

    e. Despite that, lobbying efforts to persuade DCH not to change rule to add general surgery

V. Recommendations

A. Eliminate CON Review for ALL Physician Owned Ambulatory Surgery Centers

B. Eliminate the capital threshold for diagnostic and therapeutic equipment.

C. If Commission is not willing to go that far

1. Increase capital threshold for ambsurg centers.

2. Allow the development of multispecialty ambsurg centers and centers offering general surgery.

3. Increase threshold on diagnostic and therapeutic equipment.